



Colorado Covering Kids and Families

## CHP+ Appeals

Please be sure to review the entire CHP+ appeals process for yourself on HCPF's website <http://www.chcpf.state.co.us/>. Click on "Reference Materials" then "Department Program Rules – Code of Colorado Regulations." You'll see a section titled Appeals under the Children's Basic Health Plan. Below is a brief summary.

Denials regarding eligibility, enrollment, or cost sharing may be appealed to the CHP+ Eligibility Vendor (ACS).

- Appeals should be in writing, state why the applicant is appealing, and include the case number.
- Appeals should be sent to PO Box. 929, Denver, Colorado 80201-0929 and marked **attention: appeals department**.
- Appeals must be received by ACS within 30 days of the date of the client receives notification about a decision with which they disagree. If an applicant does not receive the notice with enough time to appeal the decision within 30 days by mail they may fax their appeal to ACS at 303-893-1780. Again, be sure to mark it **attention: appeals department**. If the client does not receive notice until after the deadline, customer service recommends submitting a new application. However, if the client needed services within that time we recommend that you work the initial application to preserve coverage.
- If the application was processed by a county or other MA site, ACS will coordinate the appeal and is required to do so within 10 days of receiving the appeal request.
- Appeals must be reviewed and processed within 30 days of their receipt.
- ACS, the county, or Medical Assistance site will check the case for data entry errors and re-run for eligibility.
- The results of the appeal must be communicated in writing to the applicant within 10 business days of the review.

If an applicant disagrees with the result of the appeal, they may have their case reviewed by the Grievance Committee.

- The applicant may attend the Grievance Committee in person or by telephone.
- The applicant will be contacted with their date to attend the Grievance Committee based on the completed appeal process.
- The applicant may be represented by a person of their choosing.
- The applicant may have access to any documents that were used in making the decision that they are appealing.
- The applicant may request a translator.
- The decision of the Grievance Committee is final.

If the client is already enrolled in CHP+ and is appealing their redetermination, their benefits continue throughout the appeals process. If their appeal is unsuccessful and the client is denied continuing coverage, they will NOT be liable for any services they received during the appeal process.

*If the client is appealing a denial of benefits this is NOT the process they should follow. They should contact their HMO to find out the HMO's appeal process. Amy Scangarella is the HMO contract manager ([amy.scangarella@state.co.us](mailto:amy.scangarella@state.co.us))*